

Senate File 567 - Introduced

SENATE FILE 567

BY COMMITTEE ON WAYS AND MEANS

(SUCCESSOR TO SF 462)

(SUCCESSOR TO SSB 1167)

A BILL FOR

1 An Act relating to health care services and financing including
2 nursing facility licensing and financing and the Medicaid
3 program including third-party recovery and taxation of
4 Medicaid managed care organization premiums, and providing
5 for licensee discipline.

6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

MEDICAID PROGRAM THIRD-PARTY RECOVERY

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3 Section 1. Section 249A.37, Code 2023, is amended by
4 striking the section and inserting in lieu thereof the
5 following:

6 **249A.37 Duties of third parties.**

7 1. For the purposes of this section, "*Medicaid payor*",
8 "*recipient*", "*third party*", and "*third-party benefits*" mean the
9 same as defined in section 249A.54.

10 2. The third-party obligations specified under this section
11 are a condition of doing business in the state. A third party
12 that fails to comply with these obligations shall not be
13 eligible to do business in the state.

14 3. A third party that is a carrier, as defined in section
15 514C.13, shall enter into a health insurance data match program
16 with the department for the sole purpose of comparing the
17 names of the carrier's insureds with the names of recipients
18 as required by section 505.25.

19 4. A third party shall do all of the following:

20 a. Cooperate with the Medicaid payor in identifying
21 recipients for whom third-party benefits are available
22 including but not limited to providing information to determine
23 the period of potential third-party coverage, the nature of
24 the coverage, and the name, address, and identifying number
25 of the coverage. In cooperating with the Medicaid payor, the
26 third party shall provide information upon the request of the
27 Medicaid payor in a manner prescribed by the Medicaid payor or
28 as agreed upon by the department and the third party.

29 b. (1) Accept the Medicaid payor's rights of recovery
30 and assignment to the Medicaid payor as a subrogee, assignee,
31 or lienholder under section 249A.54 for payments which the
32 Medicaid payor has made under the Medicaid state plan or under
33 a waiver of such state plan.

34 (2) In the case of a third party other than the original
35 Medicare fee-for-service program under parts A and B of Tit.

1 XVIII of the federal Social Security Act, a Medicare advantage
2 plan offered by a Medicare advantage organization under part C
3 of Tit. XVIII of the federal Social Security Act, a reasonable
4 cost reimbursement contract under 42 U.S.C. §1395mm, a health
5 care prepayment plan under 42 U.S.C. §1395l, or a prescription
6 drug plan offered by a prescription drug plan sponsor under
7 part D of Tit. XVIII of the federal Social Security Act that
8 requires prior authorization for an item or service furnished
9 to an individual eligible to receive medical assistance
10 under Tit. XIX of the federal Social Security Act, accept
11 authorization provided by the Medicaid payor that the health
12 care item or service is covered under the Medicaid state plan
13 or waiver of such state plan for such individual, as if such
14 authorization were the prior authorization made by the third
15 party for such item or service.

16 *c.* If, on or before three years from the date a health care
17 item or service was provided, the Medicaid payor submits an
18 inquiry regarding a claim for payment that was submitted to the
19 third party, respond to that inquiry not later than sixty days
20 after receiving the inquiry.

21 *d.* Respond to any Medicaid payor's request for payment of a
22 claim described in paragraph "c" not later than ninety business
23 days after receipt of written proof of the claim, either by
24 paying the claim or issuing a written denial to the Medicaid
25 payor.

26 *e.* Not deny any claim submitted by a Medicaid payor solely
27 on the basis of the date of submission of the claim, the type
28 or format of the claim form, a failure to present proper
29 documentation at the point-of-sale that is the basis of the
30 claim; or in the case of a third party other than the original
31 Medicare fee-for-service program under parts A and B of Tit.
32 XVIII of the federal Social Security Act, a Medicare advantage
33 plan offered by a Medicare advantage organization under part C
34 of Tit. XVIII of the federal Social Security Act, a reasonable
35 cost reimbursement contract under 42 U.S.C. §1395mm, a health

1 care prepayment plan under 42 U.S.C. §1395l, or a prescription
2 drug plan offered by a prescription drug plan sponsor under
3 part D of Tit. XVIII of the federal Social Security Act, solely
4 on the basis of a failure to obtain prior authorization for the
5 health care item or service for which the claim is submitted if
6 all of the following conditions are met:

7 (a) The claim is submitted to the third party by the
8 Medicaid payor no later than three years after the date on
9 which the health care item or service was furnished.

10 (b) Any action by the Medicaid payor to enforce its rights
11 under section 249A.54 with respect to such claim is commenced
12 not later than six years after the Medicaid payor submits the
13 claim for payment.

14 5. Notwithstanding any provision of law to the contrary,
15 the time limitations, requirements, and allowances specified
16 in this section shall apply to third-party obligations under
17 this section.

18 6. The department may adopt rules pursuant to chapter 17A
19 as necessary to administer this section. Rules governing
20 the exchange of information under this section shall be
21 consistent with all laws, regulations, and rules relating to
22 the confidentiality or privacy of personal information or
23 medical records, including but not limited to the federal
24 Health Insurance Portability and Accountability Act of 1996,
25 Pub. L. No. 104-191, and regulations promulgated in accordance
26 with that Act and published in 45 C.F.R. pts. 160 - 164.

27 Sec. 2. Section 249A.54, Code 2023, is amended by striking
28 the section and inserting in lieu thereof the following:

29 **249A.54 Responsibility for payment on behalf of**
30 **Medicaid-eligible persons — liability of other parties.**

31 1. It is the intent of the general assembly that a Medicaid
32 payor be the payor of last resort for medical services
33 furnished to recipients. All other sources of payment for
34 medical services are primary relative to medical assistance
35 provided by the Medicaid payor. If benefits of a third party

1 are discovered or become available after medical assistance has
2 been provided by the Medicaid payor, it is the intent of the
3 general assembly that the Medicaid payor be repaid in full and
4 prior to any other person, program, or entity. The Medicaid
5 payor shall be repaid in full from and to the extent of any
6 third-party benefits, regardless of whether a recipient is made
7 whole or other creditors are paid.

8 2. For the purposes of this section:

9 a. "*Collateral*" means all of the following:

10 (1) Any and all causes of action, suits, claims,
11 counterclaims, and demands that accrue to the recipient
12 or to the recipient's agent, related to any covered injury
13 or illness, or medical services that necessitated that the
14 Medicaid payor provide medical assistance to the recipient.

15 (2) All judgments, settlements, and settlement agreements
16 rendered or entered into and related to such causes of action,
17 suits, claims, counterclaims, demands, or judgments.

18 (3) Proceeds.

19 b. "*Covered injury or illness*" means any sickness, injury,
20 disease, disability, deformity, abnormality disease, necessary
21 medical care, pregnancy, or death for which a third party is,
22 may be, could be, should be, or has been liable, and for which
23 the Medicaid payor is, or may be, obligated to provide, or has
24 provided, medical assistance.

25 c. "*Medicaid payor*" means the department or any person,
26 entity, or organization that is legally responsible by
27 contract, statute, or agreement to pay claims for medical
28 assistance including but not limited to managed care
29 organizations and other entities that contract with the state
30 to provide medical assistance under chapter 249A.

31 d. "*Medical service*" means medical or medically related
32 institutional or noninstitutional care, or a medical or
33 medically related institutional or noninstitutional good, item,
34 or service covered by Medicaid.

35 e. "*Payment*" as it relates to third-party benefits, means

1 performance of a duty, promise, or obligation, or discharge of
2 a debt or liability, by the delivery, provision, or transfer of
3 third-party benefits for medical services. "To pay" means to
4 make payment.

5 *f.* "Proceeds" means whatever is received upon the sale,
6 exchange, collection, or other disposition of the collateral
7 or proceeds from the collateral and includes insurance payable
8 because of loss or damage to the collateral or proceeds. "Cash
9 proceeds" include money, checks, and deposit accounts and
10 similar proceeds. All other proceeds are "noncash proceeds".

11 *g.* "Recipient" means a person who has applied for medical
12 assistance or who has received medical assistance.

13 *h.* "Recipient's agent" includes a recipient's legal
14 guardian, legal representative, or any other person acting on
15 behalf of the recipient.

16 *i.* "Third party" means an individual, entity, or program,
17 excluding Medicaid, that is or may be liable to pay all or a
18 part of the expenditures for medical assistance provided by a
19 Medicaid payor to the recipient. A third party includes but is
20 not limited to all of the following:

21 (1) A third-party administrator.

22 (2) A pharmacy benefits manager.

23 (3) A health insurer.

24 (4) A self-insured plan.

25 (5) A group health plan, as defined in section 607(1) of the
26 federal Employee Retirement Income Security Act of 1974.

27 (6) A service benefit plan.

28 (7) A managed care organization.

29 (8) Liability insurance including self-insurance.

30 (9) No-fault insurance.

31 (10) Workers' compensation laws or plans.

32 (11) Other parties that by law, contract, or agreement
33 are legally responsible for payment of a claim for medical
34 services.

35 *j.* "Third-party benefits" mean any benefits that are or may

1 be available to a recipient from a third party and that provide
2 or pay for medical services. *Third-party benefits* may be
3 created by law, contract, court award, judgment, settlement,
4 agreement, or any arrangement between a third party and any
5 person or entity, recipient, or otherwise. *Third-party*
6 *benefits* include but are not limited to all of the following:

- 7 (1) Benefits from collateral or proceeds.
- 8 (2) Health insurance benefits.
- 9 (3) Health maintenance organization benefits.
- 10 (4) Benefits from preferred provider arrangements and
11 prepaid health clinics.
- 12 (5) Benefits from liability insurance, uninsured and
13 underinsured motorist insurance, or personal injury protection
14 coverage.
- 15 (6) Medical benefits under workers' compensation.
- 16 (7) Benefits from any obligation under law or equity to
17 provide medical support.

18 3. Third-party benefits for medical services shall be
19 primary to medical assistance provided by the Medicaid payor.

20 4. *a.* A Medicaid payor has all of the rights, privileges,
21 and responsibilities identified under this section. Each
22 Medicaid payor is a Medicaid payor to the extent of the
23 medical assistance provided by that Medicaid payor. Therefore,
24 Medicaid payors may exercise their Medicaid payor's rights
25 under this section concurrently.

26 *b.* Notwithstanding the provisions of this subsection to the
27 contrary, if the department determines that a Medicaid payor
28 has not taken reasonable steps within a reasonable time to
29 recover third-party benefits, the department may exercise all
30 of the rights of the Medicaid payor under this section to the
31 exclusion of the Medicaid payor. If the department determines
32 the department will exercise such rights, the department shall
33 give notice to third parties and to the Medicaid payor.

34 5. A Medicaid payor may assign the Medicaid payor's rights
35 under this section, including but not limited to an assignment

1 to another Medicaid payor, a provider, or a contractor.

2 6. After the Medicaid payor has provided medical assistance
3 under the Medicaid program, the Medicaid payor shall seek
4 reimbursement for third-party benefits to the extent of the
5 Medicaid payor's legal liability and for the full amount of
6 the third-party benefits, but not in excess of the amount of
7 medical assistance provided by the Medicaid payor.

8 7. On or before the thirtieth day following discovery by
9 a recipient of potential third-party benefits, a recipient or
10 the recipient's agent, as applicable, shall inform the Medicaid
11 payor of any rights the recipient has to third-party benefits
12 and of the name and address of any person that is or may be
13 liable to provide third-party benefits.

14 8. When the Medicaid payor provides or becomes liable for
15 medical assistance, the Medicaid payor has the following rights
16 which shall be construed together to provide the greatest
17 recovery of third-party benefits:

18 a. The Medicaid payor is automatically subrogated to any
19 rights that a recipient or a recipient's agent or legally
20 liable relative has to any third-party benefit for the full
21 amount of medical assistance provided by the Medicaid payor.
22 Recovery pursuant to these subrogation rights shall not be
23 reduced, prorated, or applied to only a portion of a judgment,
24 award, or settlement, but shall provide full recovery to the
25 Medicaid payor from any and all third-party benefits. Equities
26 of a recipient or a recipient's agent, creditor, or health care
27 provider shall not defeat, reduce, or prorate recovery by the
28 Medicaid payor as to the Medicaid payor's subrogation rights
29 granted under this paragraph.

30 b. By applying for, accepting, or accepting the benefit
31 of medical assistance, a recipient or a recipient's agent or
32 legally liable relative automatically assigns to the Medicaid
33 payor any right, title, and interest such person has to any
34 third-party benefit, excluding any Medicare benefit to the
35 extent required to be excluded by federal law.

1 (1) The assignment granted under this paragraph is absolute
2 and vests legal and equitable title to any such right in the
3 Medicaid payor, but not in excess of the amount of medical
4 assistance provided by the Medicaid payor.

5 (2) The Medicaid payor is a bona fide assignee for value in
6 the assigned right, title, or interest and takes vested legal
7 and equitable title free and clear of latent equities in a
8 third party. Equities of a recipient or a recipient's agent,
9 creditor, or health care provider shall not defeat or reduce
10 recovery by the Medicaid payor as to the assignment granted
11 under this paragraph.

12 c. The Medicaid payor is entitled to and has an automatic
13 lien upon the collateral for the full amount of medical
14 assistance provided by the Medicaid payor to or on behalf of
15 the recipient for medical services furnished as a result of any
16 covered injury or illness for which a third party is or may be
17 liable.

18 (1) The lien attaches automatically when a recipient first
19 receives medical services for which the Medicaid payor may be
20 obligated to provide medical assistance.

21 (2) The filing of the notice of lien with the clerk of
22 the district court in the county in which the recipient's
23 eligibility is established pursuant to this section shall be
24 notice of the lien to all persons. Notice is effective as of
25 the date of filing of the notice of lien.

26 (3) If the Medicaid payor has actual knowledge that the
27 recipient is represented by an attorney, the Medicaid payor
28 shall provide the attorney with a copy of the notice of lien.
29 However, this provision of a copy of the notice of lien to
30 the recipient's attorney does not abrogate the attachment,
31 perfection, and notice satisfaction requirements specified
32 under subparagraphs (1) and (2).

33 (4) Only one claim of lien need be filed to provide notice
34 and shall provide sufficient notice as to any additional
35 or after-paid amount of medical assistance provided by the

1 Medicaid payor for any specific covered injury or illness.
2 The Medicaid payor may, in the Medicaid payor's discretion,
3 file additional, amended, or substitute notices of lien at any
4 time after the initial filing until the Medicaid payor has
5 been repaid the full amount of medical assistance provided
6 by Medicaid or otherwise has released the liable parties and
7 recipient.

8 (5) A release or satisfaction of any cause of action,
9 suit, claim, counterclaim, demand, judgment, settlement, or
10 settlement agreement shall not be effective as against a lien
11 created under this paragraph, unless the Medicaid payor joins
12 in the release or satisfaction or executes a release of the
13 lien. An acceptance of a release or satisfaction of any cause
14 of action, suit, claim, counterclaim, demand, or judgment and
15 any settlement of any of the foregoing in the absence of a
16 release or satisfaction of a lien created under this paragraph
17 shall prima facie constitute an impairment of the lien, and
18 the Medicaid payor is entitled to recover damages on account
19 of such impairment. In an action on account of impairment of a
20 lien, the Medicaid payor may recover from the person accepting
21 the release or satisfaction or the person making the settlement
22 the full amount of medical assistance provided by the Medicaid
23 payor.

24 (6) The lack of a properly filed claim of lien shall not
25 affect the Medicaid payor's assignment or subrogation rights
26 provided in this subsection nor affect the existence of the
27 lien, but shall only affect the effective date of notice.

28 (7) The lien created by this paragraph is a first lien
29 and superior to the liens and charges of any provider of a
30 recipient's medical services. If the lien is recorded, the
31 lien shall exist for a period of seven years after the date of
32 recording. If the lien is not recorded, the lien shall exist
33 for a period of seven years after the date of attachment. If
34 recorded, the lien may be extended for one additional period
35 of seven years by rerecording the claim of lien within the

1 ninety-day period preceding the expiration of the lien.

2 9. Except as otherwise provided in this section, the
3 Medicaid payor shall recover the full amount of all medical
4 assistance provided by the Medicaid payor on behalf of the
5 recipient to the full extent of third-party benefits. The
6 Medicaid payor may collect recovered benefits directly from any
7 of the following:

8 a. A third party.

9 b. The recipient.

10 c. The provider of a recipient's medical services if
11 third-party benefits have been recovered by the provider.
12 Notwithstanding any provision of this section to the contrary,
13 a provider shall not be required to refund or pay to the
14 Medicaid payor any amount in excess of the actual third-party
15 benefits received by the provider from a third party for
16 medical services provided to the recipient.

17 d. Any person who has received the third-party benefits.

18 10. a. A recipient and the recipient's agent shall
19 cooperate in the Medicaid payor's recovery of the recipient's
20 third-party benefits and in establishing paternity and support
21 of a recipient child born out of wedlock. Such cooperation
22 shall include but is not limited to all of the following:

23 (1) Appearing at an office designated by the Medicaid payor
24 to provide relevant information or evidence.

25 (2) Appearing as a witness at a court proceeding or other
26 legal or administrative proceeding.

27 (3) Providing information or attesting to lack of
28 information under penalty of perjury.

29 (4) Paying to the Medicaid payor any third-party benefit
30 received.

31 (5) Taking any additional steps to assist in establishing
32 paternity or securing third-party benefits, or both.

33 b. Notwithstanding paragraph "a", the Medicaid payor has the
34 discretion to waive, in writing, the requirement of cooperation
35 for good cause shown and as required by federal law.

1 *c.* The department may deny or terminate eligibility for
2 any recipient who refuses to cooperate as required under this
3 subsection unless the department has waived cooperation as
4 provided under this subsection.

5 11. On or before the thirtieth day following the initiation
6 of a formal or informal recovery, other than by filing a
7 lawsuit, a recipient's attorney shall provide written notice of
8 the activity or action to the Medicaid payor.

9 12. A recipient is deemed to have authorized the Medicaid
10 payor to obtain and release medical information and other
11 records with respect to the recipient's medical services
12 for the sole purpose of obtaining reimbursement for medical
13 assistance provided by the Medicaid payor.

14 13. *a.* To enforce the Medicaid payor's rights under
15 this section, the Medicaid payor may, as a matter of right,
16 institute, intervene in, or join in any legal or administrative
17 proceeding in the Medicaid payor's own name, and in any or a
18 combination of any, of the following capacities:

- 19 (1) Individually.
20 (2) As a subrogee of the recipient.
21 (3) As an assignee of the recipient.
22 (4) As a lienholder of the collateral.

23 *b.* An action by the Medicaid payor to recover damages
24 in an action in tort under this subsection, which action is
25 derivative of the rights of the recipient, shall not constitute
26 a waiver of sovereign immunity.

27 *c.* A Medicaid payor, other than the department, shall obtain
28 the written consent of the department before the Medicaid payor
29 files a derivative legal action on behalf of a recipient.

30 *d.* When a Medicaid payor brings a derivative legal action on
31 behalf of a recipient, the Medicaid payor shall provide written
32 notice no later than thirty days after filing the action to the
33 recipient, the recipient's agent, and, if the Medicaid payor
34 has actual knowledge that the recipient is represented by an
35 attorney, to the attorney of the recipient, as applicable.

1 e. If the recipient or a recipient's agent brings an action
2 against a third party, on or before the thirtieth day following
3 the filing of the action, the recipient, the recipient's agent,
4 or the attorney of the recipient or the recipient's agent,
5 as applicable, shall provide written notice to the Medicaid
6 payor of the action, including the name of the court in which
7 the action is brought, the case number of the action, and a
8 copy of the pleadings. The recipient, the recipient's agent,
9 or the attorney of the recipient or the recipient's agent, as
10 applicable, shall provide written notice of intent to dismiss
11 the action at least twenty-one days before the voluntary
12 dismissal of an action against a third party. Notice to the
13 Medicaid payor shall be sent as specified by rule.

14 14. On or before the thirtieth day before the recipient
15 finalizes a judgment, award, settlement, or any other recovery
16 where the Medicaid payor has the right to recovery, the
17 recipient, the recipient's agent, or the attorney of the
18 recipient or recipient's agent, as applicable, shall give the
19 Medicaid payor notice of the judgment, award, settlement,
20 or recovery. The judgment, award, settlement, or recovery
21 shall not be finalized unless such notice is provided and the
22 Medicaid payor has had a reasonable opportunity to recover
23 under the Medicaid payor's rights to subrogation, assignment,
24 and lien. If the Medicaid payor is not given notice, the
25 recipient, the recipient's agent, and the recipient's or
26 recipient's agent's attorney are jointly and severally liable
27 to reimburse the Medicaid payor for the recovery received to
28 the extent of medical assistance paid by the Medicaid payor.
29 The notice required under this subsection means written
30 notice sent via certified mail to the address listed on the
31 department's internet site for a Medicaid payor's third-party
32 liability contact. The notice requirement is only satisfied
33 for the specific Medicaid payor upon receipt by the specific
34 Medicaid payor's third-party liability contact of such written
35 notice sent via certified mail.

1 15. *a.* Except as otherwise provided in this section, the
2 entire amount of any settlement of the recipient's action or
3 claim involving third-party benefits, with or without suit, is
4 subject to the Medicaid payor's claim for reimbursement of the
5 amount of medical assistance provided and any lien pursuant to
6 the claim.

7 *b.* Insurance and other third-party benefits shall not
8 contain any term or provision which purports to limit or
9 exclude payment or the provision of benefits for an individual
10 if the individual is eligible for, or a recipient of, medical
11 assistance, and any such term or provision shall be void as
12 against public policy.

13 16. In an action in tort against a third party in which the
14 recipient is a party and which results in a judgment, award, or
15 settlement from a third party, the amount recovered shall be
16 distributed as follows:

17 *a.* After deduction of reasonable attorney fees, reasonably
18 necessary legal expenses, and filing fees, there is a
19 rebuttable presumption that all Medicaid payors shall
20 collectively receive two-thirds of the remaining amount
21 recovered or the total amount of medical assistance provided by
22 the Medicaid payors, whichever is less. A party may rebut this
23 presumption in accordance with subsection 17.

24 *b.* The remaining recovered amount shall be paid to the
25 recipient.

26 *c.* If the recovered amount available for the repayment of
27 medical assistance is insufficient to satisfy the competing
28 claims of the Medicaid payors, each Medicaid payor shall be
29 entitled to the Medicaid payor's respective pro rata share of
30 the recovered amount that is available.

31 17. *a.* A recipient or a recipient's agent who has notice
32 or who has actual knowledge of the Medicaid payor's rights
33 to third-party benefits under this section and who receives
34 any third-party benefit or proceeds for a covered injury or
35 illness shall on or before the sixtieth day after receipt of

1 the proceeds pay the Medicaid payor the full amount of the
2 third-party benefits, but not more than the total medical
3 assistance provided by the Medicaid payor, or shall place the
4 full amount of the third-party benefits in an interest-bearing
5 trust account for the benefit of the Medicaid payor pending a
6 determination of the Medicaid payor's rights to the benefits
7 under this subsection.

8 *b.* If federal law limits the Medicaid payor to reimbursement
9 from the recovered damages for medical expenses, a recipient
10 may contest the amount designated as recovered damages for
11 medical expenses payable to the Medicaid payor pursuant to the
12 formula specified in subsection 16. In order to successfully
13 rebut the formula specified in subsection 16, the recipient
14 shall prove, by clear and convincing evidence, that the portion
15 of the total recovery which should be allocated as medical
16 expenses, including future medical expenses, is less than the
17 amount calculated by the Medicaid payor pursuant to the formula
18 specified in subsection 16. Alternatively, to successfully
19 rebut the formula specified in subsection 16, the recipient
20 shall prove, by clear and convincing evidence, that Medicaid
21 provided a lesser amount of medical assistance than that
22 asserted by the Medicaid payor. A settlement agreement that
23 designates the amount of recovered damages for medical expenses
24 is not clear and convincing evidence and is not sufficient to
25 establish the recipient's burden of proof, unless the Medicaid
26 payor is a party to the settlement agreement.

27 *c.* If the recipient or the recipient's agent filed a legal
28 action to recover against the third party, the court in which
29 such action was filed shall resolve any dispute concerning
30 the amount owed to the Medicaid payor, and shall retain
31 jurisdiction of the case to resolve the amount of the lien
32 after the dismissal of the action.

33 *d.* If the recipient or the recipient's agent did not file a
34 legal action, to resolve any dispute concerning the amount owed
35 to the Medicaid payor, the recipient or the recipient's agent

1 shall file a petition for declaratory judgment as permitted
2 under rule of civil procedure 1.1101 on or before the one
3 hundred twenty-first day after the date of payment of funds to
4 the Medicaid payor or the date of placing the full amount of
5 the third-party benefits in a trust account. Venue for all
6 declaratory actions under this subsection shall lie in Polk
7 county.

8 *e.* If a Medicaid payor and the recipient or the recipient's
9 agent disagree as to whether a medical claim is related to a
10 covered injury or illness, the Medicaid payor and the recipient
11 or the recipient's agent shall attempt to work cooperatively
12 to resolve the disagreement before seeking resolution by the
13 court.

14 *f.* Each party shall pay the party's own attorney fees and
15 costs for any legal action conducted under this subsection.

16 18. Notwithstanding any other provision of law to the
17 contrary, when medical assistance is provided for a minor, any
18 statute of limitation or repose applicable to an action or
19 claim of a legally responsible relative for the minor's medical
20 expenses is extended in favor of the legally responsible
21 relative so that the legally responsible relative shall have
22 one year from and after the attainment of the minor's majority
23 within which to file a complaint, make a claim, or commence an
24 action.

25 19. In recovering any payments in accordance with this
26 section, the Medicaid payor may make appropriate settlements.

27 20. If a recipient or a recipient's agent submits via notice
28 a request that the Medicaid payor provide an itemization of
29 medical assistance paid for any covered injury or illness,
30 the Medicaid payor shall provide the itemization on or before
31 the sixty-fifth day following the day on which the Medicaid
32 payor received the request. Failure to provide the itemization
33 within the specified time shall not bar a Medicaid payor's
34 recovery, unless the itemization response is delinquent for
35 more than one hundred twenty days without justifiable cause. A

1 Medicaid payor shall not be under any obligation to provide a
2 final itemization until a reasonable period of time after the
3 processing of payment in relation to the recipient's receipt of
4 final medical services. A Medicaid payor shall not be under
5 any obligation to respond to more than one itemization request
6 in any one-hundred-twenty-day period. The notice required
7 under this subsection means written notice sent via certified
8 mail to the address listed on the department's internet site
9 for a Medicaid payor's third-party liability contact. The
10 notice requirement is only satisfied for the specific Medicaid
11 payor upon receipt by the specific Medicaid payor's third-party
12 liability contact of such written notice sent via certified
13 mail.

14 21. The department may adopt rules to administer this
15 section and applicable federal requirements.

16 DIVISION II

17 MEDICAID MANAGED CARE ORGANIZATION TAXATION OF PREMIUMS

18 Sec. 3. NEW SECTION. 249A.13 Medicaid managed care
19 organization premiums fund.

20 1. A Medicaid managed care organization premiums fund
21 is created in the state treasury under the authority of the
22 department of health and human services. Moneys collected by
23 the director of the department of revenue as taxes on premiums
24 pursuant to section 432.1A shall be deposited in the fund.

25 2. Moneys in the fund are appropriated to the department
26 of health and human services for the purposes of the medical
27 assistance program.

28 3. Notwithstanding section 8.33, moneys in the fund
29 that remain unencumbered or unobligated at the close of a
30 fiscal year shall not revert but shall remain available for
31 expenditure for the purposes designated. Notwithstanding
32 section 12C.7, subsection 2, interest or earnings on moneys in
33 the fund shall be credited to the fund.

34 Sec. 4. NEW SECTION. 432.1A Health maintenance organization
35 — medical assistance program — premium tax.

1 1. Pursuant to section 514B.31, subsection 3, a health
2 maintenance organization contracting with the department of
3 health and human services to administer the medical assistance
4 program under chapter 249A, shall pay as taxes to the director
5 of the department of revenue for deposit in the Medicaid
6 managed care organization premiums fund created in section
7 249A.13, an amount equal to two and one-half percent of
8 the premiums received and taxable under subsection 514B.31,
9 subsection 3.

10 2. Except as provided in subsection 3, the premium tax shall
11 be paid on or before March 1 of the year following the calendar
12 year for which the tax is due. The commissioner of insurance
13 may suspend or revoke the license of a health maintenance
14 organization subject to the premium tax in subsection 1 that
15 fails to pay the premium tax on or before the due date.

16 3. *a.* Each health maintenance organization transacting
17 business in this state that is subject to the tax in subsection
18 1 shall remit on or before June 1, on a prepayment basis,
19 an amount equal to one-half of the health maintenance
20 organization's premium tax liability for the preceding calendar
21 year.

22 *b.* In addition to the prepayment amount in paragraph
23 "a", each health maintenance organization subject to the
24 tax in subsection 1 shall remit on or before August 15, on
25 a prepayment basis, an additional one-half of the health
26 maintenance organization's premium tax liability for the
27 preceding calendar year.

28 *c.* The sums prepaid by a health maintenance organization
29 under paragraphs "a" and "b" shall be allowed as credits
30 against the health maintenance organization's premium tax
31 liability for the calendar year during which the payments are
32 made. If a prepayment made under this subsection exceeds
33 the health maintenance organization's annual premium tax
34 liability, the excess shall be allowed as a credit against the
35 health maintenance organization's subsequent prepayment or tax

1 liabilities under this section. The commissioner of insurance
2 shall authorize the department of revenue to make a cash refund
3 to a health maintenance organization, in lieu of a credit
4 against subsequent prepayment or tax liabilities under this
5 section, if the health maintenance organization demonstrates
6 the inability to recoup the funds paid via a credit. The
7 commissioner of insurance shall adopt rules establishing a
8 health maintenance organization's eligibility for a cash
9 refund, and the process for the department of revenue to make a
10 cash refund to an eligible health maintenance organization from
11 the Medicaid managed care organization premiums fund created in
12 section 249A.13. The commissioner of insurance may suspend or
13 revoke the license of a health maintenance organization that
14 fails to make a prepayment on or before the due date under this
15 subsection.

16 *d.* Sections 432.10 and 432.14 are applicable to premium
17 taxes due under this section.

18 Sec. 5. Section 514B.31, Code 2023, is amended by striking
19 the section and inserting in lieu thereof the following:

20 **514B.31 Taxation.**

21 1. For the first five years of the existence of a
22 health maintenance organization and the health maintenance
23 organization's successors and assigns, the following shall
24 not be considered premiums received and taxable under section
25 432.1:

26 *a.* Payments received by the health maintenance organization
27 for health care services, insurance, indemnity, or other
28 benefits to which an enrollee is entitled through a health
29 maintenance organization authorized under this chapter.

30 *b.* Payments made by the health maintenance organization
31 to providers for health care services, to insurers, or to
32 corporations authorized under chapter 514 for insurance,
33 indemnity, or other service benefits authorized under this
34 chapter.

35 2. After the first five years of the existence of a

1 health maintenance organization and the health maintenance
2 organization's successors and assigns, the following shall be
3 considered premiums received and taxable under section 432.1:

4 *a.* Payments received by the health maintenance organization
5 for health care services, insurance, indemnity, or other
6 benefits to which an enrollee is entitled through a health
7 maintenance organization authorized under this chapter.

8 *b.* Payments made by the health maintenance organization
9 to providers for health care services, to insurers, or to
10 corporations authorized under chapter 514 for insurance,
11 indemnity, or other service benefits authorized under this
12 chapter.

13 3. Notwithstanding subsections 1 and 2, beginning January
14 1, 2024, and for each subsequent calendar year, the following
15 shall be considered premiums received and taxable under section
16 432.1A for a health maintenance organization contracting with
17 the department of health and human services to administer the
18 medical assistance program under chapter 249A:

19 *a.* Payments received by the health maintenance organization
20 for health care services, insurance, indemnity, or other
21 benefits to which an enrollee is entitled through a health
22 maintenance organization authorized under this chapter.

23 *b.* Payments made by the health maintenance organization
24 to providers for health care services, to insurers, or to
25 corporations authorized under chapter 514 for insurance,
26 indemnity, or other service benefits authorized under this
27 chapter.

28 4. Payments made to a health maintenance organization
29 by the United States secretary of health and human services
30 under a contract issued under section 1833 or 1876 of the
31 federal Social Security Act, or under section 4015 of the
32 federal Omnibus Budget Reconciliation Act of 1987, shall not
33 be considered premiums received and shall not be taxable under
34 section 432.1 or 432.1A. Payments made to a health maintenance
35 organization contracting with the department of health and

1 human services to administer the medical assistance program
2 under chapter 249A shall not be taxable under section 432.1.

3 DIVISION III

4 NURSING FACILITY LICENSING AND FINANCING

5 Sec. 6. NEW SECTION. 135.63A **Moratorium — new construction**
6 **or permanent change in bed capacity — nursing facilities.**

7 1. Beginning July 1, 2023, the department, in consultation
8 with the department of health and human services, may impose
9 a temporary moratorium on submission of applications for new
10 construction of a nursing facility or a permanent change in
11 the bed capacity of a nursing facility that increases the
12 bed capacity of the nursing facility for an initial period
13 of twelve months. The department may extend the moratorium
14 in six-month increments following the conclusion of the
15 initial twelve-month period, but for no longer than a total of
16 thirty-six months. The department shall document, in writing,
17 the need for each extension of the moratorium.

18 2. The department, in consultation with the department
19 of health and human services, may waive the moratorium as
20 specified in this section if the department determines there
21 is a need for specialized needs beds or if a waiver request has
22 been made in the manner specified by the department.

23 Sec. 7. NEW SECTION. 135C.7A **Nursing facility license**
24 **application — required information — escrow account.**

25 1. In addition to the requirements of section 135C.7, an
26 applicant for a nursing facility license shall provide all of
27 the following information in the license application:

28 a. Information related to the applicant's financial
29 suitability to operate a nursing facility as verified by the
30 applicant.

31 b. Whether the applicant has voluntarily surrendered
32 a license while under investigation in another licensing
33 jurisdiction.

34 c. Whether another licensing jurisdiction has taken
35 disciplinary action against the applicant relating to the

1 applicant's operation of a nursing facility or whether another
2 nursing facility owned or operated by the applicant has been
3 subject to operation by a court-appointed receiver or temporary
4 manager.

5 *d.* Whether there are any complaints, allegations, or
6 investigations against the applicant pending in another
7 licensing jurisdiction.

8 2. The information or documents provided to the department
9 under this section detailing the applicant's financial
10 condition or the terms of the applicant's contractual business
11 relationships shall be confidential and not considered a public
12 record under chapter 22.

13 3. If an applicant does not have at least five years of
14 experience operating a nursing facility in this state or
15 pursuant to equivalent licensing or certification provisions
16 in any other state, the applicant shall establish an escrow
17 account containing an amount sufficient to support full service
18 operation of the nursing facility for a two-month period.
19 The Medicaid program shall be entitled to the funds held in
20 escrow if the nursing facility is subject to operation under
21 receivership pursuant to section 135C.30.

22 Sec. 8. Section 135C.10, Code 2023, is amended by adding the
23 following new subsection:

24 NEW SUBSECTION. 9A. Failure of a nursing facility licensee
25 or license applicant to establish financial suitability to
26 operate a nursing facility including failure to establish an
27 escrow account pursuant to section 135C.7A.

28 Sec. 9. Section 249L.3, Code 2023, is amended by adding the
29 following new subsection:

30 NEW SUBSECTION. 6A. A nursing facility shall not knowingly
31 pass the quality assurance assessment on to non-Medicaid
32 payors, including as a rate increase or service charge. If a
33 nursing facility violates this section, the department shall
34 not reimburse the nursing facility the quality assurance
35 assessment due the nursing facility under the medical

1 assistance program, but shall instead only reimburse the
2 nursing facility at the nursing facility base reimbursement
3 rate under the medical assistance program for one year from the
4 date the violation is discovered.

5 EXPLANATION

6 The inclusion of this explanation does not constitute agreement with
7 the explanation's substance by the members of the general assembly.

8 This bill relates to health care services and financing
9 including nursing facility licensing and financing and the
10 Medicaid program including recovery by the department of health
11 and human services (HHS or the department) from third parties
12 and taxation of Medicaid managed care organization premiums.

13 DIVISION I — MEDICAID PROGRAM THIRD-PARTY RECOVERY. The
14 bill strikes and replaces current provisions in Code section
15 249A.37 (health care information sharing) and Code section
16 249A.54 (assignment — lien).

17 Under the bill, new Code section 249A.37 (duties of third
18 parties) relates to the duties of third parties, defined
19 under the bill as "an individual, entity, or program,
20 excluding Medicaid, that is or may be liable to pay all or
21 a part of the expenditures for medical assistance provided
22 by a Medicaid payor to the recipient". The listing of
23 "third parties" includes but is not limited to a third-party
24 administrator, a pharmacy benefits manager, a health insurer, a
25 self-insured plan, a group health plan, a service benefit plan,
26 a managed care organization, liability insurance including
27 self-insurance, no-fault insurance, workers' compensation laws
28 or plans, and other parties that by law, contract, or agreement
29 are legally responsible for payment of a claim for a medical
30 service. The bill also defines terms including "Medicaid
31 payor", "recipient", "third party", and "third-party benefits".

32 The bill provides that the third-party obligations specified
33 under the bill are a condition of doing business in the state,
34 and a third party that fails to comply with these obligations
35 shall not be eligible to do business in the state.

1 The bill requires that a third party that is a carrier shall
2 enter into a health insurance data match program with HHS
3 for the sole purpose of comparing the names of the carrier's
4 insureds with the names of recipients as required by Code
5 section 505.25 (information provided to medical assistance
6 program, Hawki program, and child support services).

7 The bill specifies the duties of a third party under the
8 Medicaid program including cooperating with the Medicaid payor
9 in identifying recipients for whom third-party benefits are
10 available; accepting the Medicaid payor's rights of recovery
11 and assignment to the Medicaid payor for payments which the
12 Medicaid payor has made; accepting authorization provided by
13 the Medicaid payor that the health care item or service is
14 covered as if such authorization were the prior authorization
15 made by the third party for such health care item or service;
16 responding to inquiries from Medicaid payors regarding claims
17 for payment; and not denying claims submitted by a Medicaid
18 payor solely on the basis of the date of submission of the
19 claim, the type or format of the claim form, a failure to
20 present proper documentation, or in the case of specified
21 third-party payors solely on the basis of a failure to obtain
22 prior authorization if certain conditions are met.

23 The department may adopt administrative rules to administer
24 this Code section of the bill. Rules governing the exchange
25 of information under the bill shall be consistent with all
26 laws, regulations, and rules relating to the confidentiality or
27 privacy of personal information or medical records, including
28 but not limited to the federal Health Insurance Portability
29 and Accountability Act (HIPAA) and regulations promulgated in
30 accordance with HIPAA.

31 Under new Code section 249A.54 (responsibility for payment
32 on behalf of Medicaid-eligible persons — liability of other
33 parties) the bill includes specific provisions relating to the
34 responsibility for payment on behalf of Medicaid recipients,
35 which include both persons who have applied for and persons

1 who have received medical assistance, when other parties are
2 liable.

3 The bill provides that it is the intent of the general
4 assembly that Medicaid payors be the payor of last resort for
5 medical services furnished to recipients. All other sources of
6 payment for medical services are primary relative to medical
7 assistance provided by the Medicaid payor. If benefits of a
8 third party are discovered or become available after medical
9 assistance has been provided by the Medicaid payor, it is
10 the intent of the general assembly that the Medicaid payor
11 be repaid in full and prior to any other person, program, or
12 entity. The Medicaid payor shall be repaid in full from and to
13 the extent of any third-party benefits, regardless of whether a
14 recipient is made whole or other creditors paid.

15 The bill provides definitions for "collateral", "covered
16 injury or illness", "Medicaid payor", "medical service",
17 "payment", "proceeds", "recipient" which includes both an
18 applicant for and recipient of medical assistance, "recipient's
19 agent", "third party", and "third-party benefits".

20 The bill provides that third-party benefits for medical
21 services shall be primary relative to medical assistance
22 provided by the Medicaid payor. A Medicaid payor has all of
23 the rights, privileges, and responsibilities identified under
24 the bill, but if HHS determines that a Medicaid payor has not
25 taken reasonable steps within a reasonable time to recover
26 third-party benefits, HHS may exercise all of the rights of the
27 Medicaid payor to the exclusion of the Medicaid payor following
28 provision of notice to third parties and the Medicaid payor.

29 A Medicaid payor may assign the Medicaid payor's rights
30 under the bill, including to another Medicaid payor, a
31 provider, or a contractor. After the Medicaid payor has
32 provided medical assistance, the Medicaid payor shall seek
33 reimbursement for third-party benefits to the extent of the
34 Medicaid payor's legal liability and for the full amount of
35 the third-party benefits, but not in excess of the amount of

1 medical assistance provided by the Medicaid payor.

2 Within 30 days following discovery by a recipient of
3 potential third-party benefits, a recipient or the recipient's
4 agent, as applicable, shall inform the Medicaid payor of any
5 rights the recipient has to third-party benefits and provide
6 identifying information for any person that is or may be liable
7 to provide third-party benefits.

8 The bill specifies the rights of a Medicaid payor when
9 the Medicaid payor provides or becomes liable for medical
10 assistance, including that the Medicaid payor is automatically
11 subrogated to any rights that a recipient or a recipient's
12 agent or legally liable relative has to any third-party
13 benefit for the full amount of medical assistance provided by
14 the Medicaid payor; that the Medicaid payor is automatically
15 assigned any right, title, and interest a recipient or
16 a recipient's agent or legally liable relative has to a
17 third-party benefit by virtue of applying for, accepting, or
18 accepting the benefit of medical assistance, excluding any
19 Medicare benefit to the extent required to be excluded by
20 federal law; and that the Medicaid payor is entitled to and
21 has an automatic lien upon the collateral for the full amount
22 of medical assistance provided by the Medicaid payor to or on
23 behalf of the recipient for medical services furnished as a
24 result of any covered injury or illness for which a third party
25 is or may be liable.

26 Unless otherwise provided in the bill, the Medicaid payor
27 shall recover the full amount of all medical assistance
28 provided by the Medicaid payor on behalf of the recipient
29 to the full extent of third-party benefits. A recipient
30 and the recipient's agent shall cooperate in the Medicaid
31 payor's recovery of the recipient's third-party benefits and
32 in establishing paternity and support of a recipient child
33 born out of wedlock. The Medicaid payor has the discretion
34 to waive, in writing, the requirement of cooperation for good
35 cause shown and as required by federal law. The department may

1 deny or terminate eligibility for any recipient who refuses to
2 cooperate, unless HHS has waived cooperation.

3 Within 30 days of initiating formal or informal recovery,
4 other than by filing a lawsuit, a recipient's attorney shall
5 provide written notice of the activity or action to the
6 Medicaid payor.

7 A recipient is deemed to have authorized the Medicaid payor
8 to obtain and release medical information and other records
9 with respect to the recipient's medical services for the sole
10 purpose of obtaining reimbursement for medical assistance
11 provided by the Medicaid payor.

12 To enforce the Medicaid payor's rights, the Medicaid
13 payor may institute, intervene in, or join in any legal or
14 administrative proceeding in the Medicaid payor's own name, and
15 in a number or a combination of capacities listed in the bill.
16 An action by the Medicaid payor to recover damages in an action
17 in tort, which is derivative of the rights of the recipient,
18 shall not constitute a waiver of sovereign immunity.

19 A Medicaid payor, other than HHS, shall obtain written
20 consent from HHS before the Medicaid payor files a derivative
21 legal action on behalf of a recipient, and when a Medicaid
22 payor brings such a derivative action, the Medicaid payor shall
23 provide written notice no later than 30 days after filing the
24 action to the recipient, the recipient's agent, and, if the
25 Medicaid payor has actual knowledge that the recipient is
26 represented by an attorney, to the attorney of the recipient,
27 as applicable.

28 If an action is filed by a recipient or a recipient's agent
29 against a third party, the recipient, the recipient's agent,
30 or the attorney of the recipient or the recipient's agent,
31 as applicable, shall provide written notice to the Medicaid
32 payor of the action, including the name of the court in which
33 the action is brought, the case number of the action, and a
34 copy of the pleadings. The recipient, the recipient's agent,
35 or the attorney of the recipient or the recipient's agent,

1 as applicable, shall also provide written notice of intent
2 to dismiss the action prior to the voluntary dismissal of an
3 action against a third party.

4 Before a recipient finalizes a judgment, award, settlement,
5 or any other recovery where the Medicaid payor has the right
6 to recovery, the recipient, the recipient's agent, or the
7 attorney of the recipient or recipient's agent, as applicable,
8 shall give the Medicaid payor notice, as specified, of the
9 judgment, award, settlement, or recovery. The judgment,
10 award, settlement, or recovery shall not be finalized
11 unless the notice is provided and the Medicaid payor has
12 a reasonable opportunity to recover under its rights to
13 subrogation, assignment, and lien. If notice is not provided,
14 the recipient, the recipient's agent, and the recipient's or
15 recipient's agent's attorney are jointly and severally liable
16 to reimburse the Medicaid payor for the recovery received to
17 the extent of medical assistance paid by the Medicaid payor.

18 Unless otherwise provided, the entire amount of any
19 settlement of the recipient's action or claim involving
20 third-party benefits is subject to the Medicaid payor's claim
21 for reimbursement of the amount of medical assistance provided
22 and any lien pursuant to the claim.

23 The bill prohibits insurance and other third-party benefits
24 from containing any term or provision which purports to
25 limit or exclude payment or the provision of benefits for an
26 individual if the individual is eligible for, or a recipient
27 of, medical assistance, and any such term or provision shall be
28 void as against public policy.

29 In an action in tort against a third party in which the
30 recipient is a party, of the amount recovered in any resulting
31 judgment, award, or settlement from a third party, after
32 deduction of reasonable attorney fees, reasonably necessary
33 legal expenses, and filing fees, there is a rebuttable
34 presumption that all Medicaid payors shall collectively receive
35 two-thirds of the remaining amount recovered or the total

1 amount of medical assistance provided by the Medicaid payors,
2 whichever is less; and the remaining amount recovered shall be
3 paid to the recipient. In calculating the Medicaid payor's
4 recovered amount of medical assistance, the fee for services of
5 an attorney retained by the recipient or the recipient's legal
6 representative shall not exceed one-third of the judgment,
7 award, or settlement amount. If the recovered amount is
8 insufficient to satisfy the competing claims of the Medicaid
9 payors, each Medicaid payor shall be entitled to the Medicaid
10 payor's respective pro rata share of the recovered amount that
11 is available.

12 A recipient or a recipient's agent who has notice or
13 who has actual knowledge of the Medicaid payor's rights to
14 third-party benefits who receives any third-party benefit or
15 proceeds for a covered injury or illness, shall after receipt
16 of the proceeds pay the Medicaid payor the full amount of the
17 third-party benefits, but not more than the total medical
18 assistance provided by the Medicaid payor, or shall place the
19 full amount of the third-party benefits in an interest-bearing
20 trust account for the benefit of the Medicaid payor pending a
21 determination of the Medicaid payor's rights to the benefits.

22 If federal law limits the Medicaid payor to reimbursement
23 from the recovered damages for medical expenses, a recipient
24 may contest the amount designated as recovered damages for
25 medical expenses payable to the Medicaid payor as specified
26 in the formula under the bill. To successfully rebut the
27 formula, the recipient shall prove, by clear and convincing
28 evidence, that the portion of the total recovery which should
29 be allocated as medical expenses, including future medical
30 expenses, is less than the amount calculated by the Medicaid
31 payor pursuant to the formula. Alternatively, to successfully
32 rebut the formula, the recipient shall prove, by clear and
33 convincing evidence, that Medicaid provided a lesser amount of
34 medical assistance than that asserted by the Medicaid payor. A
35 settlement agreement that designates the amount of recovered

1 damages for medical expenses is not clear and convincing
2 evidence and is not sufficient to establish the recipient's
3 burden of proof, unless the Medicaid payor is a party to the
4 settlement agreement.

5 If the recipient or the recipient's agent filed a legal
6 action to recover against the third party, the court in which
7 such action was filed shall resolve any dispute concerning
8 the amount owed to the Medicaid payor, and shall retain
9 jurisdiction of the case to resolve the amount of the lien
10 after the dismissal of the action. If the recipient or the
11 recipient's agent did not file a legal action to resolve any
12 dispute concerning the amount owed to the Medicaid payor, the
13 recipient or the recipient's agent shall file a petition for
14 declaratory judgment. Venue for all such declaratory actions
15 shall lie in Polk county. Each party shall pay the party's own
16 attorney fees and costs for any legal action conducted under
17 this provision of the bill.

18 If a Medicaid payor and the recipient or the recipient's
19 agent disagree as to whether a medical claim is related to a
20 covered injury or illness, the Medicaid payor and the recipient
21 or the recipient's agent shall attempt to work cooperatively
22 to resolve the disagreement before seeking resolution by the
23 court.

24 With regard to medical assistance provided to a minor, and
25 notwithstanding any other provision of law to the contrary, any
26 statute of limitations or repose applicable to an action or
27 claim of a legally responsible relative for the minor's medical
28 expenses is extended in favor of the legally responsible
29 relative so that the legally responsible relative shall have
30 one year from and after the attainment of the minor's majority
31 within which to file a complaint, make a claim, or commence an
32 action.

33 In recovering any payments under the bill, the Medicaid
34 payor may make appropriate settlements.

35 The bill provides the process and limitations for a request

1 by a recipient or a recipient's agent that a Medicaid payor
2 provide an itemization of medical assistance paid for any
3 covered injury or illness via notice as specified under the
4 bill.

5 The department may adopt administrative rules to administer
6 this portion of the bill and applicable federal requirements.

7 DIVISION II — MEDICAID MANAGED CARE ORGANIZATION

8 TAXATION OF PREMIUMS. The bill relates to taxation of health
9 maintenance organizations.

10 Under current Code section 514B.31 (taxation), for the
11 first five years of the existence of a health maintenance
12 organization (HMO) or its successor, payments received by the
13 HMO for health care services, insurance, indemnity, or other
14 benefits to which an enrollee is entitled, and payments made by
15 the HMO to a provider for health care services, to insurers, or
16 to corporations authorized under Code chapter 514 (nonprofit
17 health services corporations) for insurance, indemnity, or
18 other service benefits, are not considered premiums received
19 and not taxable under Code section 432.1 (tax on gross premiums
20 — exclusions). After five years, payments received by the
21 HMO or its successor for health care services, insurance,
22 indemnity, or other benefits to which an enrollee is entitled,
23 and payments made by the HMO to a provider for health care
24 services, to insurers, or to corporations authorized under
25 Code chapter 514 (nonprofit health services corporations)
26 for insurance, indemnity, or other service benefits, are
27 considered premiums received and taxable under Code section
28 432.1. Current Code section 514B.31 also provides that certain
29 payments made by the United States secretary of health and
30 human services are not considered premiums and therefore not
31 taxable under Code section 432.1.

32 The bill amends Code section 514B.31 to exempt from
33 consideration as premiums and therefore not taxable under
34 either Code section 432.1 (tax on gross premiums — exclusions)
35 or new Code section 432.1A (health maintenance organization —

1 medical assistance program — premium tax) payments to health
2 maintenance organizations from the United States secretary of
3 health and human services under contracts issued under section
4 1833 or 1876 of the federal Social Security Act or section
5 4015 of the federal Omnibus Budget Reconciliation Act of 1987.
6 However, the bill provides that payments made to a health
7 maintenance organization contracting with HHS to administer the
8 Medicaid program shall not be taxable only under Code section
9 432.1. The bill also amends Code section 514B.31 to provide
10 that notwithstanding the provisions applicable to HMOs under
11 Code section 514B.31 relating to a premium tax, beginning
12 January 1, 2024, and for each subsequent calendar year, for an
13 HMO contracting with HHS to administer the medical assistance
14 program under Code chapter 249A, payments received by the
15 HMO for health care services, insurance, indemnity, or other
16 benefits to which an enrollee is entitled, and payments made by
17 the HMO to a provider for health care services, to insurers,
18 or to corporations authorized under Code chapter 514 for
19 insurance, indemnity, or other service benefits, are considered
20 premiums received and taxable under new Code section 432.1A.

21 The bill establishes under new Code section 432.1A the
22 parameters of the new tax on HMOs contracting with HHS to
23 administer the medical assistance program under Code chapter
24 249A. Such HMOs shall pay as taxes to the director of the
25 department of revenue for deposit in the Medicaid managed care
26 organization premiums fund an amount equal to 2.5 percent of
27 the premiums received and taxable. The premium tax shall be
28 paid on or before March 1 of the year following the calendar
29 year for which the tax is due. The commissioner of insurance
30 may suspend or revoke the license of an HMO subject to the
31 premium tax that fails to pay the premium tax on or before the
32 due date. Code sections 432.10 (sufficiency of remitted tax
33 — notice) and 432.14 (statute of limitations) apply to the
34 premium tax due.

35 An HMO subject to the new tax shall remit on or before June

1 1, on a prepayment basis, an amount equal to one-half of the
2 HMO's premium tax liability for the preceding calendar year;
3 and shall remit on or before August 15, on a prepayment basis,
4 an additional one-half of the HMO's premium tax liability
5 for the preceding calendar year. If a prepayment exceeds
6 the HMO's annual premium tax liability, the excess shall be
7 allowed as a credit against the HMO's subsequent prepayment
8 or tax liabilities. The HMO may receive a credit or a cash
9 refund in lieu of a credit against subsequent prepayment or
10 tax liabilities. The commissioner of insurance may suspend or
11 revoke the license of an HMO that fails to make a prepayment on
12 or before the due date.

13 The bill creates in new Code section 249A.13 a Medicaid
14 managed care organization premiums fund in the state treasury
15 under the authority of HHS. Moneys collected from the new
16 tax on premiums shall be deposited in the fund. Moneys in
17 the fund are appropriated to HHS for the purposes of the
18 medical assistance program. Moneys in the fund that remain
19 unencumbered or unobligated at the close of a fiscal year shall
20 not revert but shall remain available for expenditure for the
21 purposes designated. Interest or earnings on moneys in the
22 fund shall be credited to the fund.

23 DIVISION III — NURSING FACILITY LICENSING AND FINANCING.
24 The bill creates a moratorium on new construction or permanent
25 change in bed capacity for nursing facilities. The bill
26 provides that beginning July 1, 2023, the department of
27 inspections, appeals, and licensing (DIAL), in consultation
28 with HHS, may impose a temporary moratorium on submission of
29 applications for new construction of a nursing facility or a
30 permanent change in the bed capacity of a nursing facility
31 that increases the bed capacity of the nursing facility for an
32 initial period of 12 months. The department of inspections,
33 appeals, and licensing may extend the moratorium in six-month
34 increments but for no longer than a total of 36 months, and
35 must document in writing the need for each extension of the

1 moratorium. The department of inspections, appeals, and
2 licensing, in consultation with HHS, may waive the moratorium
3 if DIAL determines there is a need for specialized needs beds
4 or if a waiver request has been made in the manner specified by
5 DIAL.

6 The bill also requires an applicant for a nursing facility
7 license to provide information related to the applicant's
8 financial suitability to operate a nursing facility as verified
9 by the applicant; whether the applicant has voluntarily
10 surrendered a license while under investigation in another
11 licensing jurisdiction; whether another licensing jurisdiction
12 has taken disciplinary action against the applicant relating
13 to the applicant's operation of a nursing facility and whether
14 another nursing facility owned or operated by the applicant
15 has been subject to operation by a court-appointed receiver
16 or temporary manager; and whether there are any complaints,
17 allegations, or investigations against the applicant pending
18 in another jurisdiction. The information and documents
19 provided by the applicant detailing the applicant's financial
20 condition or the terms of the applicant's contractual business
21 relationships are confidential and not considered a public
22 record under Code chapter 22. If an applicant does not have at
23 least five years of experience operating a nursing facility in
24 this state or under an equivalent licensing or certification
25 provision in any other state, the applicant shall establish
26 an escrow account with an amount sufficient to support full
27 service operation of the nursing facility for a two-month
28 period. The Medicaid program is entitled to the funds held
29 in escrow if the nursing facility is subject to operation
30 under a receivership. Failure of a nursing facility licensee
31 or applicant to establish financial suitability to operate
32 a nursing facility including failure to establish an escrow
33 account is grounds for DIAL to deny, suspend, or revoke a
34 nursing facility license.

35 The bill also provides with regard to the nursing facility

1 quality assurance assessment imposed under Code chapter 249L
2 (nursing facility quality assurance assessment program) that a
3 nursing facility shall not knowingly pass the quality assurance
4 assessment on to non-Medicaid payors, including as a rate
5 increase or service charge. If a nursing facility violates
6 this provision, HHS shall not reimburse the nursing facility
7 the quality assurance assessment due the nursing facility
8 under the Medicaid program, but shall instead only reimburse
9 the nursing facility the nursing facility base reimbursement
10 rate under the Medicaid program for one year from the date the
11 violation is discovered.